Community-centered Approaches to Behavior and Social Change:

Models and Processes for Health and Development

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NGO Networks for Health (*Networks*) is an innovative five year global health partnership created to meet the burgeoning demand for quality family planning, reproductive health, child survival, and HIV/AIDS information and services around the world. The five collaborating organizations on the *Networks* project are: the Adventist Relief Agency (ADRA), Cooperative for Assistance and Relief Everywhere (CARE), PLAN International, Program for Appropriate Technology in Health (PATH), and Save the Children/US. NGO Networks for Health is funded through a Cooperative Agreement with the United States Agency for International Development and with matching resources from the five PVO Partners.

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Additional copies may be obtained from:

NGO Networks for Health
1620 I Street NW, Suite 900
Washington, DC 20006
Tel. 202-955-0070
Fax 202-955-1105
http://www.ngonetworks.org

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List of Acronyms

Organizations/Agencies

ADRA	Adventist Development and Relief Agency
AED	Academy for Educational Development
BASICS	Basic Support for Institutionalizing Child Survival
CAN MOVE	Community Advocacy Network: Mobilize, Validate, and Expand
CEDPA	Center for Development and Population Activities
CORE	The Child Survival Collaboration and Resources Group
EHP	Environmental Health Project
HHS	Health and Human Services
HKI	Helen Keller International
HRSA	Health Resources and Services Administration
Networks	NGO Networks for Health
PATH	Program for Appropriate Technology in Health
SARA	Support for Analysis and Research in Africa Project
SAWSO	Salvation Army World Service Office
SC	Save the Children/US
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development

Technical Terms

AIDS	Acquired Immunodeficiency Syndrome
BCC	Behavior Change Communication
CA	Cooperating Agency
CS	Child Survival
FGC	Female Genital Cutting
FP	Family Planning
HIV	Human Immune Deficiency Virus
NGO	Non-Governmental Organization
PVO	Private Voluntary Organization

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Special thanks to all those who participated in the planning meeting in January 2000. They included Bram Bailey with SAWSO; Premila Bartlett with *Networks;* Lydia Clemmons with the CHANGE Project; Elizabeth Fox with USAID; Laurie Krieger with EHP; Karen LeBan with BASICS; Nitin Madhav with USAID/BHR/PVC; Elizabeth Nisbet of HKI; Michel Pacque with Child Survival Technical Support (CSTS) Project; Mark Rasmusson with BASICS; Nancy Russell with the MNH project; Jerry Sternin with SC; Eric Swedberg with CORE and SC; Caroline Tanner of AMA Technologies; and Rikki Welch with CSTS. Don Graybill, Director of the Education, Mobilization, and Communication Division at Creative Associates International, ably facilitated this meeting, which was greatly appreciated.

The thought-provoking and inspirational presentations by Ronald Labonte, Nancy Russell, Molly Melching, Ian Campbell, April Foster, Jerry Sternin, and Monique Sternin were extremely valuable.

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Premila Bartlett
Behavior Change Communications Advisor

Introduction

Community engagement, empowerment, and ownership are key to achieving sustained behavior change for improved health and development. The challenge facing non-governmental organizations (NGOs), private voluntary organizations (PVOs), government agencies, and others is how to foster and sustain this type of active community involvement.

This issue was the impetus behind the two-day consultative forum "Community-Centered Approaches to Behavior and Social Change," organized by the Behavior Change Communication (BCC) Working Group of the Child Survival Collaboration and Resources (CORE) Group in collaboration with NGO Networks for Health (*Networks*) and the Salvation Army World Service Office (SAWSO). The CORE Group is a network of 32 PVOs that have received funding from the United States Agency for International Development (USAID) for programs to reduce child and maternal mortality in underserved populations.

The forum explored the complex interrelationships between community, health, individual behavior change, and broader social change. To accomplish this, members of the BCC Working Group and their colleagues from Community Advocacy Network: Mobilize, Validate, and Expand (CAN MOVE), an advocacy and technical working group of international health professionals experienced in and committed to community and social mobilization, identified four outstanding examples of community-centered approaches. In each of these case studies, community action led to behavior and social change. Presentation, analysis, and discussion of the case studies were the centerpiece of the forum, providing empirical evidence for the theory, strategies, and processes supporting the approaches.

Case studies used in the forum were selected based on four criteria: demonstrated impact; community involvement in decision-making, design, implementation, and evaluation; potential for scaling-up and replication; and representation, as a group, of diverse cultures, geographic areas, and funding sources. The selected case studies addressed a variety of issues—from female genital cutting (FGC) to human immunodeficiency virus/acquired immune deficiency syndrome (HIV/AIDS) to malnutrition—but all demonstrated the ability of community-centered approaches to produce stronger, healthier communities.

Organizers also invited Dr. Richard Labonte, a well known academician and practitioner of community participation and community development, to give the keynote address on the theoretical foundation and practical basis for community-centered approaches.

FORUM OBJECTIVES

The objective of the Consultative Forum on Community-Centered Approaches for Behavior and Social Change was:

- To broaden our understanding of theories, case studies, resources, and networks related to community-centered approaches for behavior and social change.

This increased understanding was expected to lead to participants' improved capacity to apply and expand community-centered approaches in their work.

This report summarizes the forum proceedings with the intent of offering practical guidance to readers—particularly those who were not at the forum—so that they can support, advocate for, design, implement, and

evaluate community-centered approaches. The report focuses on the concepts, processes, and actions that can be applied in a variety of settings—from inner-city communities in the United States to villages in rural Africa to the offices of NGOs, PVOs, and donor agencies.

Included in the report is a comprehensive listing of additional readings and resources for community-centered approaches.

FORUM PROCESS

The forum combined formal presentations of theory and the case studies with small group work and plenary discussion. Annex A is the forum agenda.

The presentations outlined key concepts, elements, and processes in community-centered approaches. The case study presentations (two each day) described the specific contexts, the issues and challenges faced, the processes used, the actions taken, and the lessons learned. Daily small group sessions focused on in-depth discussions of the topics sparked by the case studies, refinement of key issues and challenges, and recommendations for advocacy, implementation, and evaluation. Plenary sessions gave participants the opportunity for further dialogue, discussion, and clarification of issues with presenters. A resource table with additional readings and handbooks on community-centered approaches supplemented the presentations and case studies. Annex B contains a list of these resources and additional readings.

Major Harden White, Executive Director of SAWSO, welcomed participants to the forum, held at the Salvation Army National Headquarters. Ms. Victoria Graham, CORE Group Manager, reiterated the welcome and highlighted the importance of PVOs and NGOs working together. Mr. Eric Swedberg, Child Survival Specialist of Save the Children/US (SC) and Chair of the BCC Working Group, explained the purpose and background of the forum. Gita Pillai, the forum facilitator, presented the objective of the forum. Members of the BCC Working Group introduced each of the presenters.

Fifteen of the 60 participants completed workshop evaluation forms. Of these, most (13) were somewhat or very satisfied with the forum. Thirteen said they expected the forum to make some or substantial difference in the way they designed, implemented, or evaluated programs, and 13 felt that they would be somewhat or completely able to apply the ideas and strategies of the forum to their work. Several commented that the presentations were the most rewarding part of the forum.

A Forum Participant Speaks:

"As a result of attending this forum I understand that it is my responsibility to:

Translate complex community concerns around public health issues into compelling political priorities at the local level and to donors;

Advocate for community-level change through a process of participatory learning;

Document community actions and community change in my community;

Assist my community and organization in developing new instruments and new measures that demonstrate the success of community development processes;

Continue to look to the community itself for answers to social problems."

FORUM PARTICIPANTS AND PRESENTERS

Forum participants included a range of representatives from NGOs, PVOs, USAID cooperating agencies, donor, and government institutions. Several participants came from community-based organizations and government agencies of the United States, highlighting and reconfirming the fact that community engagement in health and development is an issue of concern throughout the world, not only in developing countries. Annex C includes a list of participants.

Presenters' diverse backgrounds and perspectives complemented their expertise and commitment to community-centered approaches. Brief biographies of presenters follow.

Dr. Ronald Labonte is the director of the Saskatchewan Population Health and Evaluation Research Unit and Professor of Community Health and Epidemiology at the University of Saskatchewan, Canada. He has done much work with native or aboriginal peoples as well as other communities in Canada, Australia, and New Zealand. His numerous consultancies include work with the United Nations Children's Fund (UNICEF) and the University of South Africa. Dr. Labonte has more than 200 publications to his name; one is a chapter in *Community Organizing and Community Building for Health*, a book that has inspired and guided many community mobilization practitioners.

Nancy Russell, director of social mobilization of the Maternal and Neonatal Health Project of JHPIEGO Corporation, seconded by the Center for Population and Development Activities (CEDPA), works with partner organizations to strengthen the involvement of community members in programs, with a particular focus on reproductive health. Prior to joining CEDPA headquarters in 1998, Ms. Russell lived in Nepal for seven years—two as a volunteer and five as CEDPA resident advisor. Under her direction, CEDPA took the lead in organizing the National Safe Motherhood Network. *Women on the Move*, developed and published by CEDPA/Nepal, highlights the success stories of women literacy class graduates. While working as a volunteer in Nepal, Ms. Russell founded a women's training program in Nepal, DIDI BAHINI. She has a Master of Arts degree in Nonprofit Administration from the University of San Francisco, California, and has worked as a director and fundraiser for a variety of community-based organizations.

Dr. Ian Campbell is an international health consultant to the Salvation Army International Headquarters in London, England. Prior to joining headquarters staff in 1990, he worked as chief medical officer with the Salvation Army in Zambia for seven years. Dr. Campbell's main professional interests are behavior change in the context of HIV/AIDS and developing a working culture of facilitation by international NGOs through a capacity development approach. He has collaborated extensively with United Nations Development Program, the United Nation Joint Program on HIV/AIDS, and other international organizations, and has many publications.

April Foster is the coordinator of the Salvation Army's Regional HIV/AIDS, Health, and Development Program in Africa, based in Nairobi, Kenya. Her work involves coordination and facilitation of program design, evaluation, concept transfer, participatory evaluation, and capacity-building of local teams in field-based programs in 12 countries. Prior to that, she worked for four years in Zimbabwe, where she coordinated country-wide HIV/AIDS and community development program initiatives for the Salvation

Army. She has also worked as a teacher and administrative assistant in the Caribbean for three years. She has a Master of Arts in Education.

Molly Melching arrived in Senegal in 1974 as an exchange student from the University of Illinois to the University of Dakar. Ms. Melching described the experience of immersion in Senegalese culture as "love at first sight." After completing her Master's degree, she remained in Senegal as a Peace Corps volunteer and created a children's center through the Ministry of Culture. She has lived in Senegal ever since. In 1991, Ms. Melching founded *Tostan*, a Senegalese NGO focusing on rural development and women's education. *Tostan* was a finalist for the Conrad N. Hilton Prize, was nominated for the UNICEF Maurice Pate Prize, and was chosen by the United Nations Cultural, Educational, and Scientific Organization in 1995 as one of the most innovative nonformal education programs in the world. Ms. Melching won the University of Illinois Alumni Humanitarian Award in 1999. Despite her numerous activities, Ms. Melching has still found time to author several books and articles.

Jerry Sternin, a former assistant dean of students at Harvard University Business School, has been a Save the Children director in Bangladesh, Philippines, Viet Nam, Egypt, and Myanmar since 1985. He has also served as a Peace Corps volunteer in the Philippines and as a Peace Corps director in Mauritania, Nepal, and Rwanda. Mr. Sternin and his wife Monique pioneered the community-based application of the positive deviance approach to nutrition.

Monique Sternin has been working in development since 1985 in Bangladesh, Egypt, Viet Nam, and Myanmar. Together with her husband Jerry, Ms. Sternin developed the positive deviance approach, which she has applied to eradication of FGC in Egypt and to nutrition in Viet Nam. She has also helped organizations in Bhutan, Cambodia, Mali, Mozambique, and Nepal to implement the approach. She is the co-author of *Designing Community-Based Nutrition Programs Using the Hearth Model and the Positive Deviance Approach: A Field Guide* and has a Masters of Education degree from Harvard University.

Keynote Address

Health, Participation, and Community: Understanding the Basis for Community-Centered Approaches

Ronald Labonte outlined key principles and practices supporting community-centered approaches to health and development.

HEALTH AND PARTICIPATION

Health is determined by the social and economic conditions and context in which people live, and health is tied to the quality of social relationships—the "glue that binds us together as people." The health of people who live in places where there is active, ongoing community participation—collective identification, analysis, and action to change the conditions producing poor health—is better than that of people in communities where there is little or no participation. But, community participation is not just a means to achieve the end goal of health. Equally or more important are the ways in which communities are engaged and their relationships with outside groups such as PVOs and government agencies.

In addition to improved health, the benefits of participation include:

- Better program decisions,
- Better use of resources,
- Better policy decisions,
- Better social capital—trust and social connection.

WHO IS COMMUNITY?

A community is a group of individuals with a common interest and an identity of themselves as a group. Two characteristics distinguish community from other groups: organization and the quality of sharing and caring. To be a community requires an organized group coming together around an issue.

An outside agency can foster community participation by two means:

1. Supporting an existing group, and
2. Organizing a new group.

COMMUNITY PARTICIPATION: ADVICE FOR OUTSIDE AGENCIES

Be explicit about the basis for choosing to support an existing group or to organize a new one. Outside agencies can be resources for and partners in community participation, but they need to clearly specify why they are pursuing one course of action or one group over another.

Always know who is in the community and why.

Do not hold communities responsible for conditions not created by them. Conventional views of community as "the other," the "not us" (e.g., the village, the poor, the members of a certain ethnic group) run the risk of seeing the community as the positive solution to health problems, when responsibility for the conditions creating the problems lies outside the community.

Avoid "bureaucratizing" community groups. Community participation is not a matter of inviting citizens to be part of an institutional structure or bureaucratic process; it is a strategic process that recognizes the

different capacities, positions, and interests of the groups involved and explicitly states what each can do to foster change.

Link local to regional to national to global issues. Community concerns and local decision-making are central to community participation, but decision-making about policy and economic resources determining health often takes place at levels beyond the local community. Outside agencies have the structures to facilitate the expansion of networks and make sure that community participation always moves up to regional, national, and global levels.

Strategize around community group concerns. When an outside agency has difficulty identifying how it can address community concerns and issues, working with existing community groups can help gain entry.

Appreciate community leaders' opinions as the only data that matter. The results of community health surveys can describe the prevalence of contributing health problems and practices. But, when the findings do not coincide with community perceptions of priority problems, which may include housing, crime, or unemployment, the likelihood for engaging people's participation and sustaining activities beyond funding is reduced.

Think "high-risk conditions," not "high-risk groups." When high-risk groups become the focus of efforts to improve health, the locus of change is in the individuals who are part of the group. In contrast, community participation aims to change the context and conditions in which people live.

Combine long-term plans with short-term fun activities. Community participation is an ongoing process, but change often takes years. Events such as fairs can keep motivation high while also serving as an opportunity to recruit people to contribute to longer-term efforts. "Communities thrive in action but die in committee."

Recognize that it takes a long time to build a community from the ground up. In places where the concept of community as an organized group does not exist, despite many different existing affiliations such as neighborhoods and ethnic groups, it may be necessary to build or organize a community. This usually requires working on an issue identified by one or two key individuals. Often, this issue is not the same as the issue that funding agencies have identified as a priority.

Three Principles of Community Participation

1. Talk to us when you have something really important to say,
2. Come to us when you have a question only we can answer, and
3. Tell us how our answer changes your thinking.

FROM A COMMUNITY-BASED PROGRAM TO A COMMUNITY DEVELOPMENT PROCESS—AND BACK

A community-based program, the "typical approach" to addressing health and development problems, contrasts with a community development process in many ways, but the boundaries between the two approaches are permeable. Community development promotes self-reliance—communities' ability to negotiate for external resources—not self-sufficiency, which means a community mobilizes its own resources and skills from within.

A Forum Participant Speaks:

"*If you come here to help me, you're wasting your time. But if you come here because your liberation [your health] is bound up in mine, let us begin.*"

—Lily Walker, Australian Aboriginal Organizer

In a community-based program:

- The problem is named in advance, e.g., malnutrition, low birthweight, usually by outside agency staff. But, the problem may not be important to community members;
- The program has defined time lines, which are often too brief to resolve the problem;
- Changes in personal knowledge or behaviors are the goal, rather than extending the program to more important changes in underlying social and environmental conditions;
- Decision-making power lies largely with professionals or outside agencies, which can create a less empowered community group.

In contrast, a community development process:

- Involves organizing or supporting groups on their named issues;
- Calls for longer-term, more intense work
- Has the goal of increasing groups' capacity to assess, analyze, and act;
- Constantly negotiates and deliberately names power relations.

Making the boundaries permeable and shifting from a program approach to a development process calls for "working outside the program box." To make this shift requires:

- An analytical framework of health determinants,
- Expertise in community development,
- Enabling internal agency policies,
- Understanding managers,
- A different approach to evaluation and accountability.

A community development process can be applied to a program to help transform it. The program must ask and answer questions such as "How will the program:

- Improve community participation?
- Increase problem assessment capacities?
- Develop local leadership?
- Contribute to new, empowering organizations?
- Improve resource mobilization?"

A program can promote self-reliance by asking and answering "How will the program:

- Strengthen links to other organizations and people?
- Enhance community ability to ask why?
- Increase community control in program management?
- Help create equal relationships with outside agents?"

Programs that have set donor objectives and indicators can make use of a community development process by working with friends and allies within the outside agency and within the funder to gain support of managers at all levels of the hierarchy. Understanding the context in which managers operate and negotiating at each level what is needed to be done can help assure that resources flow to the community.

Community development demands an ethic of partnership and consultation—not a commitment to help.

Case Study

Case Study 1: Social Mobilization - Building Community: A Catalytic Approach

Nancy Russell presented the catalytic approach to social mobilization as a practical approach to creating an environment that supports individual and normative change.

CATALYTIC APPROACH TO SOCIAL MOBILIZATION

The catalytic approach to social mobilization evolved from UNICEF's success with social mobilization around universal childhood immunization in the 1980s and more recent experiences in the United States and Canada with the use of events, such as the AIDS Walk, to raise issues and build a sense of community. The catalytic approach relies on an event or an idea as a catalyst to mobilize multiple sectors, form alliances to address a critical health issue, develop organizational capacity, and build a community of advocates with a shared vision. During the last five years, the catalytic approach has been used in Nepal to launch annual National Condom Days and the Clean Delivery Day, which led to the creation of a Safe Motherhood Network. The White Ribbon Alliance for Safe Motherhood represents a global effort using the catalytic approach.

CEDPA:

"*Social mobilization involves planned actions and processes to reach, influence, and involve all relevant segments of society across all sectors from the national to the community level to create an enabling environment and effect positive behavior change.*"

National Condom Days: Catalysts for Social Mobilization

In the Far Western Region of Nepal, 50 to 100 percent of the adult male population works in India most of the year, returning home for short visits to celebrate important festivals with their families. The men's return for Dasain, a major Hindu festival, became the catalyst for the first Condom Day in 1995. Twenty-six national and international organizations, including government, formed a coalition and worked with community-based organizations, health centers, and local government officials in 30 districts to hold low-cost activities that combined education and entertainment to raise awareness of the importance of using condoms for family planning and to prevent sexually transmitted diseases and AIDS. Condom Day activities, including rallies, street dramas, puppet shows, and fairs with games and competitions, reached men while they were home for the holiday. Radio and television broadcasts, accompanied by a public event in the capital Kathmandu, reached national audiences.

The success of the first Condom Day led to the decision to make it an annual event. Each year the organizing coalition promotes a new theme with coordinated messages. Local businesses often sponsor local activities. National-level participants support local initiatives through the joint production and dissemination of BCC materials, training, and follow-up activities. Coalition members created activity guidelines to assist communities to design their own actions and coordinate messages. The manual, *Talking Together,* guides the development and implementation of regular women's groups that discuss AIDS issues at the community level. Roving educators, trained to circulate in crowds on market days as well as Condom Day, engage in dialogue with members of the public.

The success of Condom Days also served as a catalyst for subsequent social mobilization around reproductive health issues—Clean Delivery Day followed, leading to the development of the Safe Motherhood Network in Nepal, which sparked the creation of the global White Ribbon Alliance for Safe Motherhood.

THE ACTION PROCESS

In all the cases where the catalytic approach was used, the actions grew from a need to build support for an issue. In most cases, the issue had been previously addressed by several small groups in isolation and without a coordinated effort. The process of the catalytic approach to social mobilization involves these steps:

- A person or group of people identify a need to move an issue forward;
- A larger group of individuals and organizations is formed to test the interest level and gain support;
- Enthusiasm to take action develops in the group;
- The group prepares a plan that uses an event or special occasion as a focal point;
- Participating groups coordinate and distribute awareness and action messages using a variety of media;
- Informal alliances and networks form;
- The original event catalyzes further action.

ELEMENTS OF THE CATALYTIC APPROACH

There are six key elements that run throughout the catalytic approach to social mobilization:

1. **Catalyst**: A catalyst is an agent of change. It can be a person, a group, an action, an event, or an idea. The catalyst is the focal point for building alliances and organizing actions;

2. **Cost-effectiveness**: Working together and pooling resources saves money. Condom Day events never cost more than US$2,000, and the cost of Clean Delivery Day was only US$4,000;

3. **Collaboration and community-building**: Collaboration among international and national NGOs, government, community-based organizations, and small and large businesses creates a sense of community and builds trust. Involving individuals and groups from multiple levels and sectors of society leads to lasting coalitions;

4. **Compromise**: Effective coalitions call for give-and-take in decision-making;

5. **Continuity**: The trust and commitment developed among partners leads to new joint initiatives. Support from international organizations for routine functions can help ensure continuity, but responsibility for organizing and implementing events remains with local organizations; and

6. **Capacity-building**: Planning and carrying out joint events and follow-up activities develop new connections, new skills, and new leaders. Local or international NGOs can facilitate the formation of lasting alliances and improved organizational capacities.

The social mobilization process can be measured. Indicators of change include:

- Coalitions formed,
- Policies enacted or modified,
- New leaders emerging,
- Gender equity.

NECESSARY SKILLS

The skills and attributes needed for the catalytic approach to social mobilization include the ability to:

- Foster networks and coalitions,
- Develop leadership at community and national levels,

- Work with the media,
- Generate enthusiasm,
- Organize events,
- Monitor and evaluate activities,
- Manage conflict,
- Communicate effectively with a range of groups.

In addition, the three "Ps" are essential—passion, perseverance, and planning.

LESSONS LEARNED

- Ideas originating at the "grasstops"—the national or global levels—can spread out by serving as catalysts for events and actions at the grassroots level.

- People are part of the solution, not the target audience. The catalytic approach to social mobilization addresses behavior change at all levels, among all individuals, not just among the "beneficiaries" of health and social services. It is of the people and by the people.

- Health issues go beyond mobilizing people to use health services.

- Sustained action results from a sense of community.

- The themes of the International Conference on Population and Development (the Cairo Conference)—people's participation, human rights, democracy, and gender equity— provided a compelling rationale for a donor to support social mobilization as a new approach to health issues.

- An ally within the donor agency, who was willing to take a chance on a new approach to health issues, was critical to obtaining initial financial support.

- Social mobilization brings results:
  - The social mobilization approach to universal childhood immunization increased worldwide coverage from 20 percent to 80 percent in just six years.
  - Reported intent to use condoms and dialogue between men and women about reproductive health increased after Condom Days in Nepal.
  - Use of clean home delivery birth kits was much higher in districts where Clean Delivery Day events were held in Nepal.

- The catalytic approach standardizes and reinforces BCC efforts.

- Events raise awareness and break down communication barriers.

- Events generate enthusiasm when education and entertainment are combined.

- Event planning and implementation brings together unlikely partners, creates new alliances, and generates national networks.

- Events are low cost.

- Events are an uncontroversial way of initiating dialogue and organizing people for change.

- The catalytic approach creates the potential for sustained positive political and social change.

Case Study

Case Study 2: Human Rights Educational and Social Transformation

Molly Melching told the story of how more than 150 Senegalese villages have joined together and decided to abolish the practice of FGC and to end other practices that violate women's and children's human rights.

PARTICIPATORY HUMAN RIGHTS EDUCATION: THE FOUNDATION

Tostan means " breaking out of the egg" in Wolof. An NGO founded in 1991, *Tostan* began with a two-year nonformal education program for women in a single village. Over the next few years, this program spread to other villages and expanded to incorporate new themes and skills and extended learning to whole villages. Human rights are a key theme of the program. Today, the education program includes several components:

A two-year literacy and numeracy program. Mainly for women, this program is divided into six thematic modules, including health and hygiene, management, and leadership.

A six-month village empowerment program. A follow-up to the literacy component, this program has modules on feasibility studies, income generation, and other themes.

A three-month human rights community program extends human rights education to the whole village and also covers conflict resolution, democracy, and natural resources.

Tostan does not leave a village at the end of an education program cycle. It continues to build a long-term relationship through support for credit programs and other initiatives evolving from the education program.

All of the education programs share certain features. They:

- Use national languages;
- Focus on problem-solving;
- Link learning with daily life and village development;
- Use and value cultural traditions such as song, dance, poetry, and proverbs;
- Are based on findings from years of participatory research;
- Are non-directive, allowing learners to determine the content and joint actions;
- Are managed by a village committee, which oversees the facilitators or teachers and decides how and if to pay them.

The overall approach to human rights education involves encouraging learners to relate their personal experiences to human rights and to apply this understanding to a broader context. In the basic education program, women learn about their rights, discuss how to put them into practice, and role play situations where they apply their rights. The community human rights education program includes the study of five major human rights instruments:

1. The Universal Declaration of Human Rights (1948),

2. The International Covenant on Economic, Social, and Cultural Rights (1976),

3. The International Covenant on Civil and Political Rights (1976),

4. The United Nations Convention on the Elimination of All Forms of Discrimination Against Women (1992), and

5. The United Nations Convention on the Rights of the Child (1959).

Using flip charts with simplified interpretations of the various rights, villagers discuss human rights violations and make decisions about actions they can take to ensure their rights. They create songs, dances, and dramas around the different articles and use these to facilitate a public dialogue around subjects that have never been openly discussed before. When a community has completed the human rights education program, it becomes a "human rights community."

LEARNING LEADS TO COURAGEOUS DECISIONS AND SOCIAL MOBILIZATION

In village after village, human rights education has led to social transformation. Public discussion, often in the traditional circle where decisions are made, produces consensus for action. Decisions have included:

- End to early marriage,
- End to sending young girls to cities to work as maids,
- End to domestic violence,
- Birth registration for all children,
- Education for girls,
- End to FGC.

Abolishing Female Genital Cutting: A Growing Social Movement

In July 1997, the residents of a single village jointly decided to end the tradition of FGC. With support from local leaders and in front of 20 journalists, the community made the first public declaration stating their opposition to the practice. But the village residents recognized they could not do it alone. The community imam traveled from village to village in the region discussing the negative effects of FGC and telling of the first village's declaration. In early 1998, 13 villages issued a joint declaration. The news spread. Eighteen villages of another region also formulated a similar public call renouncing the practice. By mid 2000, almost 200 of the approximately 5,500 villages where FGC is practiced had joined the movement. *Tostan* expects the initiative to grow and anticipates that 800 villages will be able to "tip the scales," leading to a nationwide consensus.

These grassroots initiatives influenced national policy. Shortly after the first declaration, the President of Senegal proposed a national law ending the practice; a few months later, legislation was enacted. The Government acknowledged the human rights' basis for the change and the risk that the new law could drive the practice underground. It called upon *Tostan* to continue its human rights education throughout Senegal.

Human Rights Communities Join Together

Human rights communities have formed a federation to create a broader movement for human rights in Senegal. In a groundbreaking meeting, men, women, young people, and children from the human rights communities met together and elected a woman as president of the federation and a 10-year-old youth as a vice president. The federation developed a four-point program, which is the basis for the communities' ongoing human rights education in their own and other communities. The four points are:

1. End FGC,
2. Eliminate early and childhood marriage,
3. Register all children at birth, and
4. Advance girls' education.

Villagers then lead a process of social mobilization, characterized by:

- Gaining support from local and religious leaders for the decisions;
- Consultation and dialogue with a network of neighboring villages to obtain their support for the decisions;
- Public declarations of the decision, made jointly by a group of villages, in the presence of the media and national authorities, and with festivities and individual testimony;
- Advocacy, negotiation, and mediation to mobilize resources to carry out actions.

LESSONS LEARNED

Education is essential to social transformation. Participatory, non-directive education that facilitates dialogue, values local tradition, and is based on discussion of personal experiences leads to social change.

Bringing about social change calls for two processes: 1) village identification and analysis of problems, based on interpretation of human rights instruments; and 2) social mobilization led by villagers. Although *Tostan* gives funds for transportation and lunches, the movement for change is led by villagers.

Public declarations opposing human rights violations such as FGC are a way to safely end the practice. Women need to know they can safely—without risk to their ability to marry and fulfill important cultural roles—stop the practice. The value of the public declaration lies in its explicit commitment to change: "We would never go back on our word."

Entire communities—networks of villages—must join together to end human rights violations. One village alone can not do it.

Involving all members of the community—men, women, and children—is critical. In order to gain the support of men, village women who wished to push forward with their decision to end human rights violations told the men, "We can't do it without you."

A focus on human rights allows change to occur peacefully and confers equal dignity to all. Human rights classes are now used as forum for negotiation and mediation of conflicts as a way to avoid going to court.

Media coverage is very important. The presence of journalists at public declarations helped reconfirm the sincerity of the announcements. Subsequent coverage by local journalists in local languages spread the message further and gave additional credibility to the movement.

Change takes a long time. Although the movement to end FGC and other human rights violations has now taken on its own momentum, it would not have been possible without *Tostan*'s investment in relationships with villages over a 10-year period.

Identifying and working with allies within donor agencies, who understand the need for time and flexibility, can gain support when there is initial resistance. When *Tostan* first began its education program, it found the individual most sympathetic to its approach within a donor agency, invited this person to visit a program in action, and demonstrated the use of a module. This experience convinced the donor agency to fund program expansion.

Human rights are a theme that can be easily incorporated into a variety of nonformal education programs.

Grassroots mobilization for human rights can influence national policies and legislation.

Case Study

Case Study 3: Home Care and Community Counselling: A Process for Expanding a Capacity Development Approach to HIV/AIDS-Related Care and Prevention

Ian Campbell and April Foster, accompanied by Alison Rader, described the Salvation Army's experiences with the synergistic processes of home care and community counseling for HIV/AIDS and analyzed how these processes became the foundation for a program-support approach that opens up community capacity for implementing and measuring change.

COMMUNITY CAPACITY DEVELOPMENT

Human relationship development—creating and nurturing a sense of "connectedness" between and among individuals, families, a community, and the "helper group"—is the core issue of community capacity development. Central to community capacity development are key concepts, which experience has shown to be transferable from culture to culture. These concepts include:

- Change is possible;
- Communities have capacity to determine and measure their own change;
- Care, characterized by presence, is essential to long-term, sustained prevention efforts;
- Hope is present within communities.

The dynamic link between the home, relationally defined groups (particularly neighborhoods), and an institutional environment (the helper group) is the context in which community capacity for change is developed. In contrast to predetermined models for an AIDS response at the community level, a community capacity-development approach calls for 1) a concept analysis of care, community, change, and hope as themes

Chikankata's Journey of Change

Chikankata is a village of about 1,000 people in the Southern province of Zambia. A school/hospital complex in Chikankata serves a catchment population of around 100,000. In 1987, the son of a senior village headman became so depressed with his AIDS diagnosis that he set fire to his hut. His distressed father requested that a hospital team facilitate a conversation among the headmen of the local area—thus emerged the first community counseling encounter.

Ritual cleansing was a subject raised indirectly at this meeting. Ritual cleansing is the ceremonial release of the spouse or partner of a deceased person from that partnership through an action involving a member of the deceased's family. With further discussions, it became clear that an episode of sexual intercourse between the deceased's partner and a member of the deceased's family was a common pattern for ritual cleansing. Hospital staff started to counsel individuals and families on the clear risk environment created by this practice. Families who provided home care to members dying of AIDS who received family counseling began to avoid ritual cleansing through sexual intercourse.

During a community counseling process in 1989, ritual cleansing by sexual intercourse became a public matter of community concern when the senior village headmen identified it as a significant issue affecting village well being. Over the next 18 months, they wrestled with the subject, and in a 1990 meeting of all headmen, 90 percent voted to "outlaw" ritual cleansing by sexual intercourse.

This decision persuaded the area chief, and in time, other chiefs heard about it and started to refer to him. Subsequently, at a meeting of the chiefs of Zambia the issue was discussed along with the capacity of Chikankata community to make this kind of decision. Chikankata community has also taken action to address other issues that may constitute risk in the environment, including alcohol, sexual expression, and HIV transmission.

important to local community life, and 2) a team facilitation process by a helper group.

Inspired by changes in the community of Chikankata, Zambia, the community capacity-development approach has been the foundation for more than 50 programs in 38 countries.

HOME-BASED CARE

Home-based care builds on the concepts of care by "being with" or presence, as distinct from the dominant approach of "providing care." It is care by participation, by listening, by reflecting with individuals and family members. Home-based care nurtures people's opportunity to embrace the future with hope. Many faiths share these concepts.

Home-based care is relational and occurs in the living circumstances of people. The home-based care process involves:

- Follow-up of a person with HIV from a hospital, clinic, or program to the home, through invitation;
- A team of two to three people that provides personal attention to the person with HIV in the home while interacting with other family members present to help create a culture of inclusion;
- Conversation with everyone together before departure, whenever possible;
- Responding to neighbors' inquiries by giving the question back in a way that helps the people asking to reflect on their own concerns about AIDS and HIV.

Giving the question back allows the community to define the issues of concern: does the question reflect concern about the person being visited, or is there a broader concern about their own susceptibility and community vulnerability to HIV/AIDS? The second type of question is often an invitation to the team to come back and can serve as an entry point to public community discussion leading to a more sustained community counseling process. Giving the question back to the community, when accompanied by the community counseling processes, can help reduce the stigma often associated with HIV/AIDS.

A Listening Invitation:

"*It is clear that you want to tell someone something. How can we help you with that?*"

COMMUNITY COUNSELING

Community counseling works synergistically with the home-care process, making the connection to the wider community for prevention and facilitating desire and action for change. Community counseling is an ongoing series of facilitated community discussions where community members explore and acknowledge feelings and issues, assess community norms and actions, consider choices, and make decisions and commitments about the life of the community.

Community counseling is a process for helping a community to acknowledge emotional dimensions of issues such as HIV and AIDS:

- Relationships,
- Intimacy,
- Family life and future,
- Collective rights and responsibilities.

The stages in community counseling, which are often concurrent, are:

- Community discovery,
- Relationship-building,
- Problem identification,
- Agreement on strategies for change,
- Shared measurement of change,
- Agreement on next steps.

Home Visits, Community Counseling, and Change in Uganda

Over the last five years, 15 communities in Eastern Uganda have been engaged in a process of change, supported by home visits and the community counseling process. Community-initiated and community-sustained actions include:

- Income-generating projects such as charcoal and sugarcane sales and pig rearing to support orphans and widows,
- Conversion of local bars into schools and churches,
- Changes in drinking times at community bars,
- Documentation and participatory evaluation of processes and changes.

Community counseling helps sustain change over a long period of time by following community concerns and facilitating participation and ownership of the process of change.

SHARED CONFIDENTIALITY

Effective integration of relational home care and the community counseling process depends on recognition of the capacity of local communities for shared confidentiality. Shared confidentiality refers to the very common process whereby information seeps out from individuals—deliberately, nonverbally, or unintentionally—and becomes shared among the group or community, often in expanding and overlapping circles of relationships. The information may be seen as private or personal to the individuals concerned, but it is not secret.

This shared knowledge of a situation helps the home-care team and the participants in the home environment to make the connection to the wider community for prevention through the community counseling process. Counseling helps to shift the focus from person-centered awareness to shared, issue-centered concern.

FACILITATION TEAMS

A team facilitation approach is a critical element of community capacity development. The team facilitation approach is applicable to capacity development in communities of all natures from organizations and government agencies to local and regional program teams to villages and neighborhoods. The team facilitation approach is characterized by:

- Working as teams,
- A relational mindset,
- Working by invitation,
- Focus on capacity development of local teams,
- A spirit of inclusion,
- Experiential learning as opposed to an expertise base,
- Transfer of learning between communities and countries through on-site program-to-program visits.

In practice, facilitation shares the same values, beliefs, and practices as counseling and makes use of:

- Strategic questioning,
- Active listening,
- Reflecting together,
- Giving questions back,
- Summarizing,
- Group decision-making,
- Participatory tools.

LESSONS LEARNED

- Approaches that help bring out the capacity of local communities to name, act for, and measure their own change have been undervalued.
- Discussions about sexuality can occur across the gender divide when they take place in the context of hope, care, and future.
- Intergenerational relationships are essential to sustained change.
- Western interpretations of the concept of confidentiality as absolute secrecy may undermine existing community processes and capacities for defining prevention and taking action.
- Training can "disempower" communities if it does not build on existing community knowledge and skill bases.
- Making the link between care and prevention calls for expansion from the bottom up and attention to process.
- The need to scale up approaches runs the risk of replacing the participation that is necessary to bring about community-determined change with intervention and externally-determined expectations, which undermine community capacity development.
- The community capacity-development approach has a scope that allows helper groups and others to reflect on the human and spiritual sense of the world as an international family.
- The capacity-development approach is also relevant to countries of the North. In these countries, the availability of treatments and associated complacency about prevention has weakened the relational approach to the linkage of care with change.
- The capacity-development approach is relevant to organizations that seek to support, organize, and stimulate wider-scale responses to HIV/AIDS and other health issues.
- Organizations that try to believe in and bring out the capacity of local implementer teams need a working organizational culture of facilitation in contrast to a tendency to prescribe and intervene.
- When organizations truly facilitate, rather than intervene, mutual learning is possible, and this in turn can enhance the capacity and environment for South-North learning.
- A belief in organizational change often coincides with a shift away from an interventionist approach.
- The opportunity to strengthen the community capacity-development approach is now.

Case Study

Case Study 4: Positive Deviance: A Paradigm for Addressing Today's Problems Today

Jerry and Monique Sternin described experiences with positive deviance, a development approach that identifies local solutions to problems within a community and suggests immediate strategies for action, using local resources. The approach has been used in 15 countries to address malnutrition, and it has also been used successfully in Egypt for advocacy for FGC eradication. The positive deviance approach is also being piloted to address behavioral and social change issues as diverse as HIV/AIDS, safe motherhood, and obesity.

POSITIVE DEVIANCE DEFINED

"*Positive deviance is a departure, a difference, or deviation from the norm resulting in a positive outcome.*"

In every community of the world, there are certain individuals whose uncommon behaviors or practices enable them to outperform or find better solutions to problems than their neighbors with whom they share the same resource base. For example, in a village where large portions of the children are malnourished, there will be a few equally poor families with well nourished children. The latter families are termed "positive deviants."

Identifying these positive deviants—and their beliefs and practices—can reveal hidden resources already present in the environment from which it is possible to devise solutions that are cost-effective, sustainable, and internally owned and managed.

The positive deviant approach holds that the presence of positive deviants in a community is evidence that viable solutions to complex problems can be found today before the underlying causes of the problem—poverty, lack of access to adequate sources of water and sanitation, etc.—are addressed.

CRITERIA FOR THE USE OF THE POSITIVE DEVIANCE APPROACH

The positive deviant approach is most appropriately utilized to inform program design when:

- The objective is social or behavioral change in prevalent practices;
- The problem to be addressed is widespread or the norm (e.g., more than 60 percent do the behavior to be changed); and
- There are some individuals (a minority of the population) in the community who already exhibit the desired (positive deviant) behavior.

POSITIVE DEVIANCE INQUIRY: DISCOVERING SOLUTIONS BASED ON COMMUNITY KNOWLEDGE

The positive deviance inquiry is the tool that allows the discovery of the unique practices and beliefs that enable the positive deviant members of the community to go against prevailing norms or find better solutions to problems than their neighbors. Because the positive deviance approach is based on community knowledge, the solutions arising from it are culturally appropriate.

Illustrative Uses of Positive Deviance

ISSUE	COMMUNITY	POSITIVE DEVIANT BEHAVIOR
HIV/AIDS	Brothel Clients Injection-Drug Users Widows of AIDS Victims	Exclusive Condom Use Use of Clean Needles/Syringes Able to Support Children
Healthy Pregnancy	Husbands of Pregnant Women	Do Work for Wives
Breastfeeding	Mothers of Infants Under 6 Months	Exclusive Breastfeeding
FGC	Girls Parents/Grandparents Husbands	Not Circumcised Oppose FGC Marry Uncircumcised Women
Trafficking of Girls	Communities with High Incidence of Trafficking	Families with No Girls Trafficked
Girls' Education	School-Age Girls	Girls Attending School

When used to explore what enabled some families in Vietnam to have well nourished children, the inquiry process involved the following steps:

- Community identification of the norms that affect the nutritional status of children;
- Identification of positive deviant children (well nourished children from poor families);
- Home visits to look for what the positive deviant families do differently, including:
  - Feeding,
  - Caring, and
  - Health-seeking practices;
- Analysis of findings;
- Design of interventions that enable other community members to access and act upon this knowledge.

Common Foods but Uncommon Practices

The positive deviance inquiry in the first four pilot communes in Vietnam found that in every case where a poor family had a well nourished child, the mother or caretaker went to the rice paddies and collected tiny shrimps and crabs and added these to the child's diet, along with greens from sweet potato tops. Although readily available and free for the taking, the conventional wisdom held these foods to be inappropriate or even dangerous for young children. These practices, along with others such as more frequent feedings, good hygiene, and timely seeking of health care, provided enough of an advantage to produce an adequately nourished child despite the poverty of the family.

In the case of FGC in Egypt, a modification of this process answered the question "How has it been possible for the few women who are not circumcised to escape the social and religious pressure to undergo the procedure to which their neighbors of the same religious, social, and economic status have succumbed?" Based on participatory learning and action methodologies, the steps were:

- An orientation workshop for NGO staff and local partners,
- Identification of positive deviants in the community,
- In-depth interviews of positive deviants,
- Analysis of positive deviant interviews,
- Action planning.

Convincing Words for Advocacy

In Egypt, the in-depth interviews of positive deviant individuals explored their actions and strategies to overcome problems engendered by their uncommon behavior and asked for specific words, metaphors, and arguments they used successfully. These phrases were then incorporated into advocacy actions. Some of the most convincing words and messages used by positive deviant individuals were:

"Circumcision is like slaughtering the girl."

"This part of the body is like the ear or the eye."

"Girls' behavior depends on how you raise them. Most prostitutes are circumcised."

"This organ was created by Allah for something good, not something bad."

"The one who is circumcised has trouble with her husband."

OPPORTUNITIES TO ACCESS AND ACT UPON NEW KNOWLEDGE

In Vietnam, the intervention that came out of the positive deviance inquiry did not result in messages; instead, it gave families of malnourished children the opportunity to practice new behaviors. Mothers brought their children to nutrition education and rehabilitation sessions in neighborhood homes for two weeks. The "price of admission" was one of the positive deviant foods identified during the positive deviance inquiry. Assisted by volunteer mothers, they practiced preparing, cooking, and feeding their children, and interacted with other mothers. A subsequent two-week session at home reinforced these practices.

This program was characterized by:

- A focus on behavior change;
- Learning by doing in a safe, accepting, and interactive environment;
- Peer support to encourage caretakers to embrace new practices;
- Witnessing positive, visible change in the child.

Community management and ownership of the program occurred through:

- Community participation in the cycle of assessment, analysis, and actions;
- Community monitoring of progress using a public score board;
- Involvement of village health committees, village health unit personnel, health volunteers, and families—making nutrition an issue for all;
- Experiencing the impact of the program and the repetition of the newly acquired behaviors with younger siblings.

THE LIVING UNIVERSITY: SCALING-UP

To facilitate the expansion of the program to hundreds of other villages in Vietnam, a "living university" was created. Government, international NGO, and village representatives spend two weeks visiting various villages in different phases of the program—villages in their first year, villages in their fourth year, and "graduate" villages. Upon return, "university students" implement the program in one village, which serves as a "mini living university."

POSITIVE DEVIANCE AND ADVOCACY

In Egypt, the positive deviant approach was used as a powerful tool for advocacy against the practice of FGC. Based on the findings of the in-depth interviews, NGOs, their local partners, and positive deviant individuals carried out the following actions:

- Home visits, teaching advocacy songs to children, talking to colleagues;
- Convincing mothers and other decision-makers not to circumcise their daughters;
- Public awareness meetings with testimony of positive deviant individuals;
- Peer advocacy groups for circumcised girls, young men married to circumcised women;
- Continuing to identify and interview positive deviant individuals in the community;
- Development and dissemination of BCC materials using the words and messages of positive deviant individuals;
- Dramas and puppet shows that include characterization of positive deviant individuals;
- Including profiles of consent positive deviant individuals in newsletters;
- Expansion of the positive deviance approach to new communities.

LESSONS LEARNED

The positive deviant approach brings results. In Vietnam, where the positive deviance nutrition program was expanded to more than 250 communities, moderate and severe malnutrition in children under the age of 3 in those communities was reduced by 55 to 85 percent. In Egypt, all project partners reported that they started to talk openly about FGC and advocate against the practice; two thirds reported they successfully convinced at least one other person or family member not to circumcise daughters.

The positive deviant approach respects community wisdom. It focuses on community assets, not needs. It tells communities "You have the answer here today in your village."

The positive deviant approach is a catalyst for sustainable change. The solutions to problems come from within the community and are based on existing resources.

The positive deviance approach is an empowering process. It helps program staff and others to lose their fear of public discussion of "taboo" subjects, enhances the advocacy capacity of NGOs and their partners, and transforms positive deviant individuals into advocates.

The positive deviance approach is an effective BCC tool. It has immediate impact, provides powerful messages through personal testimony, and strengthens linkages between individuals and organizations.

The positive deviant approach can be applied to groups and institutions as well as individuals. For example, it can be used to find out why one health center is highly attended while others within the same district have very few clients.

The term "positive deviance" makes people pay attention to community knowledge. Although some may say a positive deviant is nothing more than a "good role model," the name can help focus attention on existing resources for solutions to problems.

An outside agency that specifically states its interest, e.g., "we do nutrition," gives the community the opportunity to say "no." Although the positive deviance approach begins with a problem identified by an outside agency (e.g., malnutrition), rather than with an open-ended process of community naming of problems, it also begins with the knowledge that some community members have already solved the specific problem. This avoids the potential hypocrisy of telling a community that it has the answers to all its problems, when that may not be the case.

Community Centered Approaches: Common Themes

The presenters introduced new models for health promotion that challenge the PVO, NGO, cooperating agency, and donor communities to think differently about behavior and social change and health.

BEHAVIOR CHANGE AND SOCIAL CHANGE GO HAND IN HAND

"*The issue is not where we start, but how to travel the road*"

Although the tensions between community-centered approaches and more conventional development models are very old, it is a false battle to portray the former as a matter of social change and the latter as a question of behavior change. The critical distinction lies in the source of the authority to decide which behavior to change—is it the community or is it an outside agency?

Behaviors are contextual; group conditions and context drive individual behavior. Programs move back and forth between changes in individual behavior and changes in context. The keys to a community-centered approach are the process of how a program moves in and out from one to another and an explicit acknowledgment of the ethical, theoretical, and empirical basis for making choices about changes.

COMMON THEMES

The case studies of community-centered approaches had several elements in common. All involved:

- Local knowledge,
- Local issues,
- Experiential learning (learning by doing),
- Immediately tangible short-term benefits and some long-term change,
- Connection with service delivery,
- Concept of community ownership,
- Building on strengths and capacities, not on weaknesses.

Other repeated themes included:

- Authentic human relationships and a sense of connectedness;
- Trust;
- Courage to think and act differently; to speak publicly on issues;
- Hope for the future, to overcome resignation, apathy, and cynicism;
- Caring;
- Fun and festivities;
- Facilitation and dialogue;
- Alliances and partnerships among community groups and organizations;
- Allies and supporters within donor agencies;
- Capacity development;
- Human rights;
- The importance of process;
- Recognition that change takes a long time.

BARRIERS TO AND FACILITATORS OFCOMMUNITY-CENTERED APPROACHES

The small group work and plenary discussions identified factors and conditions that affect outside agencies' or helper groups' ability to use community-centered approaches.

Barriers included:

- Donor funding cycles and mechanisms:
  - Predetermined objectives and indicators that do not allow for community definition of issues,
  - Time frames that are too short to allow for building relationships with communities and to effect changes;
- Lack of expertise in community-centered approaches;
- Heterogeneous nature of communities;
- Risk that community-identified concerns may not be within outside agencies' scope of action.

Facilitating conditions and keys to success included:

- Commitment, energy, and enthusiasm for mutual learning and community-centered approaches among individuals, formal and informal groups within organizations, and across organizations;
- Existing formal and informal community structures and systems;
- Linkages with community partners;
- Sufficient time;
- Flexibility;
- Process analysis;
- Willingness to accept community perspectives and community-defined concerns;
- Recognition that communities change over time;
- Approaching donors as partners;
- Creativity in proposal writing and program implementation.

A Forum Participant Speaks:

"*We are not here to help, but the relationship between the two of us is essential tot he well-being of the community*"

Looking Ahead: Next Steps

Participants suggested steps and actions that they and their organizations can take to advance community-centered approaches.

Be aware that socially supportive communities lead to better health. Use the existing body of evidence substantiating the connections between community development and health outcomes in funding proposals and in advocacy work within organizations and with donors.

Recognize our own cultural, intellectual, and institutional mindsets, agendas, and limitations.

Change our thinking about projects, programs, and relationships with communities. Think:

- Concerns analysis, not needs assessment;
- High-risk conditions, not high-risk groups;
- Participation as a transformational process, not a means to an end;
- Honesty and transparency in dialogue between insiders and outsiders as paramount, not control of the program and process;
- Facilitator or catalyst, not implementer of interventions.

Shape cultural change within our own organizations by:

- Ongoing advocacy for and demonstration of community-centered approaches;
- Building participatory and capacity-building approaches into organizational policies;
- Specifically stating and explaining the meaning of concepts and approaches;
- Making team facilitation approaches the standard of operation;
- Forming partnerships and networks with other organizations;
- Validating community voices through documentation and sharing;
- Seeking and sharing guidance on community-centered approaches.

Foster and advocate for cultural change within donor organizations by:

- Identifying supporters of community-centered approaches within donor agencies ("positive deviant donors"), recognizing and learning from them;
- Sharing the factors that lead to successful relationships between communities and NGOs;
- Bringing donor representatives to communities to witness community-centered approaches in action;
- Convening meetings and workshops for donors that share the evidence and offer positive examples of community development and scaling-up;
- Promoting transparency between targeted health programs and underlying social and economic causes of health problems.

Prepare project proposals that:

- Build in sufficient time (e.g., a year) to explore community concerns,
- Make explicit that objectives are subject to revision pending community input,
- Incorporate existing evidence of the value of community-centered approaches.

Build programs that make use of the models, processes, and concepts presented at this forum:

- Concentrate on building relationships;
- Begin with the positive in the community;
- Combine community-centered approaches with national-level communication strategies;
- Link community programs with policy advocacy and change;
- Take advantage of large events to get the word out, mobilize new constituencies, and create nurturing networks;
- Involve the community in defining, implementing, and using evaluation.

Continue to research, document, and disseminate the links between participation, capacity-building, and health:

- Locate narrow program goals within broader social development indicators. Track and monitor how program work factors into social development. Utilize parallel tracking (see box);
- Go beyond looking at donor-defined outcomes and ask the community to define what changes occurred;
- Document the process of participation as an end in itself;
- Refine concepts and measures of scaling-up to distinguish between social movement-based scaling-up (e.g., changes in ritual cleansing traditions) and scaling-up in institutional structures or policies (e.g., national legislation).

Get involved in volunteers effort in our own communities.

Be willing to give up control.

Commit to doing things differently.

Parallel Tracking: Defining and Using Indicators of Community Capacity

Parallel tracking is a participatory evaluation process that allows a program to determine how it is contributing to community capacity, development, and empowerment. Parallel tracking occurs along with monitoring of conventional health program indicators.

Defining community capacity goals and building them into a program begins with an analysis of universal domains of community development and empowerment:

- Community participation,
- Local leadership,
- Empowering organizational structures,
- Problem assessment capacities,
- Resource mobilization,
- Critical analysis—"asking why,"
- Links with other organizations and people,
- Relationships with outside agencies,
- Control over program management.

In a planning workshop, community members and program planners prepare four or five statements to indicate qualitative differences within each of the domains and rank or order the statements. These statements then become the basis for selecting development and empowerment goals and indicators. To define differences within domains and arrive at goals, a community asks of each domain:

- What are the elements of this domain that are important to our situation, community, and problem?
- Where are we now and why?
- Where should we be and why?
- What do we need to get there?
- What can the program do to help us get there?
- What do we want the program to do?

By periodic review—determining which statements best reflects a community's situation at a given time through key informant interviews, focus group discussions, and review of documentation—it is possible to track change in community capacity.

Annex A: Forum Agenda

THURSDAY, APRIL 13, 2000

8:30	Registration
9:00	Welcome and Introduction of Forum
9:15	Keynote Address: Health, Participation, and Community by Ronald Labonte
9:45	Social Mobilization—Building Community: A Catalytic Approach by Nancy Russell
10:05	Q & A with Ron and Nancy
10:30	Coffee & Tea Break
10:45	Home Care and Community Counseling: A Process for Expanding a Capacity Development Approach to HIV/AIDS-related Care and Prevention by Ian Campbell, and April Foster
11:20	Open Space & Discussion groups
12:15	Lunch
1:30	Small Group Work Continues
2:00	Group Presentations
3:30	Break
3:45	Panel Discussion
4:40	Evaluation of the Day

FRIDAY, APRIL 14, 2000

8:30	Resource Tables
9:00	Snapshot of Previous Day
9:10	Human Rights Education and Social Transformation by Molly Melching
9:50	Positive Deviance: A Paradigm for Addressing Today's Problems Today by Jerry & Monique Sternin
10:30	Break
10:45	Open Space
11:00	Group Work
12:30	Lunch
1:30	Presentations of Group Work
2:30	From Discussion to Action - formal suggestions for linkages, mentoring, site visits, advice, and resource people
3:45	Closing Remarks

Annex B: Resources and Additional Readings

GENERAL

Minkler, M. (ed.) *Community Organizing and Community Building for Health.* London: Rutgers University Press, 1997. Health, Participation, and Community.

COMMUNITY

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Annex C: List of Forum Participants

PRESENTERS

Campbell, Ian
IanCampbell@salvationarmy.org
Salvation Army International Headquarters
101 Queen Victoria Street
London
EC4P 4EP
United Kingdom
44 (020) 7332-8080 (phone)
44 (020) 7489 1410 (fax)

Foster, April
Salvation Army International Headquarters

Labonte, Ronald
ronald.labonte@usask.ca
1610-125 5th Ave. North
Saskatoon, Saskatchewan
Canada
S7K 6A

Melching, Molly
info@tostan.org
Tostan
BP 326
Thiès, Senegal
221 (51) 3427 (fax)

Russell, Nancy
Nrussell@CEDPA.org
c/o Maternal and Neonatal Health Project/
JHPIEGO
Browns Wharf
1615 Thames St.
Baltimore, MD 21231

Sternin, Jerry
jsternin@scusmyanmar.org
Save the Children/US
54 Wilton, Road
Westport, CT 06880
(203) 221-7272 (phone)
(203) 221-37799 (fax)

Sternin, Monique
jsternin@scusmyanmar.org
c/o Save the Children USA

PARTICIPANTS

Bailey, Bram
Bram_Bailey@usn.salvationarmy.org
SAWSO

Barth, Erika
ebarth@usaid.gov
USAID

Bartlett, Premila
PBartlett@dc.savechildren.org
NGO Networks for Health (*Networks*)

Bateman, Massee
batemanom@ehproject.org
Environmental Health Project (EHP)

Capps, Jean Meyer
jcapps@erols.com

Charleston, Renee
renee@foothill.net
Consultant

Chung, Eunyong
echung@usaid.gov
USAID

Clark, Sam
sclark@path-dc.org
PATH

Coverton-Colemen, Jill
jillc@ccfusa.org
Christian Children's Fund, Inc.

Crook, Barb
bcrook@path.org
PATH

Dash, Della
ddash@usaid.gov
USAID, Bureau of Humanitarian Responsive/Office of Private Voluntary Cooperation

Dean, Susanne
susanne@sccoast.net
Community Coalition of Horry County
South Carolina

DeMarco, Renee
info@advocatesforyouth.org
Advocates for Youth

Dearden, Kirk
kdearden@aed.org
Linkages/Academy for Educational Development (AED)

DeGraaff, Becky
bdgraaff@compuserve.com
Adventist Development and Relief Agency

DuVerlie, Elizabeth
eduverli@jhuccp.org
Adventist Development and Relief Agency

El Feraly, Manamad
Consultant

Gryboski, Kristina, PhD
kgrybos@PATH-dc.org
PATH

Henderson, Ann
ahenderson@worldvision.org
World Vision

Hirschey, Ann
ahirschey@usaid.gov
USAID

Jensen, Elise
ejensen@projhope.org
Project HOPE

Keane, Vincent
vkeane@hrsa.gov
HHS

Kittle, Bonnie
bkittle@mindspring.com
CARE

Krieger, Dr. Laurie
kriegerLE@EHProject.org
Environmental Health Project (EHP)

Kureshy, Nazo
nazo_kureshy@jsi.com
MotherCare/John Snow, Inc. (JSI)

Laursen, Kirsten
klaursen@hki.org
Helen Keller International (HKI)

Learner, Howard
hlearner@hrsa.gov
HHS

LeBan, Karen
kleban@basics.org
BASICS

Leburg, Corey
cleburg@savechildre.org
NGO Networks for Health (*Networks*)

Lissit, Stacey
Stacy_Lissit@
usn.salvationarmy.org
SAWSO

Luna, Jennifer
lunaj@plan.geis.com
Plan International USA, Inc.

Magalhaes, Rebecca
RMagalhaes@llli.org
La Leche League International

Makalou, Kalle
Kmakalo@PATH.org
PATH

Malouin, Rebecca
rmalouin@jhsph.edu
Johns Hopkins University/School of Public Health

McNulty, Judiann
mcnulty@care.org
CARE

Meyers, Janet
jmeyers@africare.org
AFRICARE

Morrow, Melanie, M
mmorrow@wr.org
World Relief Corporation (WRC)

Newton, Nancy
luna@tidalwave.net
Consultant

Nisbet, Elizabeth
enisbet@hki.org
HKI

Niyonzima, Jean Marie
ief@iefusa.org
International Eye Foundation

Olaya, Clara
olacla@paho.org
Pan American Health Organization

Otchere, Susan
Sotchere@dc.savechildren.org
NGO Networks for Health (*Networks*)

Pacque, Michael
mpacque@macroint.com
Child Survival Technical Support (CSTS)

Palmer,Anne
annecpalmer@cs.com
PATH

Pierre-Louis, June
jpierre-louis@hki.org
HKI

Rader, Alison
ARaderSA@aol.com
SAWSO

Rader, Lyell
SAWSO

Rasmuson, Mark
mrasmuso@basics.org
BASICS

Rosales, Alfonso
arosales@catholicrelief.org
Catholic Relief Services

Rosenbaum, Julia
jrosenba@aed.org
Change Project/AED

Sarriot, Eric, G., MD
esarriot@jhsph.edu
Johns Hopkins University/School of Public Health

Settles, Denise
dsettles@usaid.gov
USAID

Shafritz, Lonna
lshafrit@smtp.aed.org
SARA Project/AED

Shaver, Theresa
Tshaver@dc.savechildren.org
NGO Networks for Health (*Networks*)

Starbuck, Eric, S
estarbuck@dc.savechildre.org
Save the Children/US

Sussman, Linda
lsussman@usaid.gov
USAID

Swedberg, Eric
eswedber@savechildren.org
Save the Children/US

Tobing, Sharon
Sharon.Tobing@att.net
CORE

Welch, Karen
kwelch@usaid.gov
USAID

Winkler, Jennifer
jwinkle@PATH.org
PATH

Wollinka, Olga
owollinka@wr.org
WRC